






City of Mesa Health Plan – Medical Plan Summary of Benefits (OE Guide)


Medical Services	Basic Choice PPO Plan Summary	
	In-Network	Out-of-Network
Annual Deductible	You pay \$550/ Individual \$1,650/ Family	You pay \$1,000/ Individual \$3,000/ Family
Coinsurance	Plan pays 50%	Plan pays 25%
Annual Out-of-Pocket Maximum (includes deductible, copays & coinsurance)	You pay \$4,500/ Individual \$9,000/ Family	None
Physician Office Visit	You pay \$20 copay	Plan pays 25% after deductible
ER Visit	Plan pays 50% after deductible	Plan pays 50% after deductible
Alternative Health Care (acupuncture, naturopath, homeopath)	Not Covered	Not Covered
Preventive Care & Immunizations	Plan pays 100%	Not Covered
Basic Choice Prescription Drugs		
Rx Services		
Annual Out-of-Pocket Maximum (separate from medical; includes RX deductible & coinsurance)	You pay \$2,100/ Individual \$4,200/ Family	
Annual Deductible (separate from medical)	You pay \$250/person/year	
Retail – 30 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay 20% (min \$5 max \$50) You pay 25% (min \$30 max \$100) You pay 40% (min \$50 max \$200) 	
Mail Order/CVS Retail – 90 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay 20% (min \$10 max \$100) You pay 25% (min \$50 max \$200) You pay 40% (min \$80 max \$300) 	

Medical Services	Choice PPO Plan Summary	
	In-Network	Out-of-Network
Annual Deductible	You pay \$300/ Individual \$900/ Family	You pay \$1,000/ Individual \$3,000/ Family
Coinsurance	Plan pays 80%	Plan pays 60%
Annual Out-of-Pocket Maximum (includes deductible)	You pay \$2,300/ Individual \$6,900/ Family	None
Physician Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
ER Visit	Plan pays 80% after deductible	Plan pays 80% after deductible
Alternative Health Care (acupuncture, naturopath, homeopath)	Plan pays 80% after deductible, up to \$1,000/year	Plan pays 60% after deductible, up to \$1,000/year
Preventive Care & Immunizations	Plan pays 100%	Not Covered
Choice Prescription Drugs		
Rx Services		
Annual Out-of-Pocket Maximum (separate from medical; includes RX deductible)	You pay \$4,300/ Individual \$6,300/ Family	
Annual Deductible (separate from medical)	You pay \$50/person/year (Retail Brand drugs only) (Waived on Generic and all Mail order drugs)	
Retail – 30 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay 20% (min \$5 max \$50) You pay 25% (min \$30 max \$100) You pay 40% (min \$50 max \$150) 	
Mail Order/CVS Retail – 90 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay 20% (min \$12.50 max \$100) You pay 25% (min \$75 max \$200) You pay 40% (min \$125 max \$300) 	

Medical Services	Copay Choice PPO Plan Summary	
	In-Network	Out-of-Network
Annual Deductible	\$0	You pay \$1,000/ Individual \$3,000/ Family
Coinsurance	N/A	Plan pays 60%
Annual Out-of-Pocket Maximum (includes deductible & copays)	You pay \$3,300/ Individual \$6,600/ Family	None
Physician Office Visit	You pay \$20 copay	Plan pays 60% after deductible
ER Visit	You pay \$100 copay (\$200 if admitted)	You pay \$100 copay (\$200 if admitted)
Alternative Health Care (acupuncture, naturopath, homeopath)	Not Covered	Not Covered
Preventive Care & Immunizations	Plan pays 100%	Not Covered
Copay Choice Prescription Drugs		
Rx Services		
Annual Out-of-Pocket Maximum (separate from medical)	You pay \$3,300/ Individual \$6,600/ Family	
Annual Deductible	None	
Retail – 30 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay \$10 You pay \$40 You pay \$75 	
Mail Order/CVS Retail – 90 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay \$20 You pay \$80 You pay \$150 	

Medical Services	Basic Choice PPO Plan Schedule of Benefits	
	In-Network	Out-of-Network
Annual Deductible	You pay \$550/ Individual \$1,650/ Family	You pay \$1,000/ Individual \$3,000/ Family
Coinsurance	Plan pays 50% after deductible	Plan pays 25% after deductible
Annual Out-of-Pocket Maximum (includes deductible, copays & coinsurance)	You pay \$4,500/ Individual \$9,000/ Family	None
Physician Office Visit	You pay \$20 copay for OV; all other services Plan pays 50% after deductible	Plan pays 25% after deductible
ER Room Visit	Plan pays 50% after deductible (emergency services only)	Plan pays 50% after deductible (emergency services only)
Urgent Care Facility	Plan pays 50% after deductible	Plan pays 25% after deductible
Preventive Care & Immunizations	Plan pays 100%	Not Covered
Alternative Health Care (acupuncture, naturopath, homeopath)	Not Covered	Not Covered
Hospital Services (require pre-cert)	Plan pays 50% after deductible	Plan pays 25% after deductible
Outpatient Surgery Services (requires pre-cert)	Plan pays 50% after deductible	Plan pays 25% after deductible
Skilled Nursing Facility (SNF)/Sub-Acute Care Facility (LTAC) (require pre-cert and physician authorization)	Plan pays 50% after deductible to a maximum of 60 days/person/year	Plan pays 25% after deductible to a maximum of 60 days/person/year (combined with in-network)
Home Health Care/Home Hospice/Home Infusion Skilled Nursing Services (require pre-cert)	Plan pays 50% after deductible to a maximum of 60 visits/person/year	Plan pays 25% after deductible to a maximum of 60 visits/person/year (combined with in-network)
Rehabilitation Services	Physical, occupational, pulmonary, cardiac, music and speech therapy as defined under the plan (may require pre-cert)	
	Plan pays 50% after deductible	Plan pays 25% after deductible
Chiropractic visits (25/person/calendar year)	Plan pays 50% after deductible	Plan pays 25% after deductible
X-Ray, Diagnostic and Lab	Plan pays 50% after deductible	Plan pays 25% after deductible
Behavioral/ Mental Health Office Visits	You pay \$20 copay, no deductible	Plan pays 25% after deductible
Durable Medical Equipment (DME)	Includes DME rentals and purchases as defined and covered under the Plan (requires pre-cert for DME over \$1,000)	
	Plan pays 50% after deductible	Plan pays 25% after deductible
Basic Choice Prescription Drugs		
Rx Services		
Out-of-Pocket Maximum (separate from medical)	You pay \$2,100/ Individual \$4,200/ Family	
Annual Deductible	You pay \$250/person	
Retail – 30 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay 20% (min \$5 max \$50) You pay 25% (min \$30 max \$100) You pay 40% (min \$50 max \$200) 	
Mail Order/CVS Retail – 90 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay 20% (min \$10 max \$100) You pay 25% (min \$50 max \$200) You pay 40% (min \$80 max \$300) 	

Medical Services	Choice PPO Plan Schedule of Benefits	
	In-Network	Out-of-Network
Annual Deductible	You pay \$300/ Individual \$900/ Family	You pay \$1,000/ Individual \$3,000/ Family
Coinsurance	Plan pays 80% after deductible	Plan pays 60% after deductible
Annual Out-of-Pocket Maximum (includes deductible, copays & coinsurance)	You pay \$2,300/ Individual \$6,900/ Family	None
Physician Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
ER Room Visit	Plan pays 80% after deductible (emergency services only)	Plan pays 60% after deductible (emergency services only)
Urgent Care Facility	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive Care & Immunizations	Plan pays 100%	Not Covered
Alternative Health Care (acupuncture, naturopath, homeopath)	Plan pays 80% after deductible, up to \$1,000/person/year	Plan pays 60% after deductible, up to \$1,000/person/year
Hospital Services (require pre-cert)	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Surgery Services (require pre-cert)	Plan pays 80% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility (SNF)/Sub-Acute Care Facility (LTAC) (require pre-cert and physician authorization)	Plan pays 80% after deductible to a maximum of 60 days/person/year	Plan pays 60% after deductible to a maximum of 60 days/person/year (combined with in-network)
Home Health Care/Home Hospice/Home Infusion Skilled Nursing Services (require pre-cert)	Plan pays 80% after deductible to a maximum of 60 visits/person/year	Plan pays 60% after deductible to a maximum of 60 visits/person/year (combined with in-network)
Rehabilitation Services	Physical, occupational, pulmonary, cardiac, music and speech therapy as defined under the plan	
	Plan pays 80% after deductible	Plan pays 60% after deductible
Chiropractic visits (25/person/calendar year)	Plan pays 80% after deductible	Plan pays 60% after deductible
X-Ray, Diagnostic	Plan pays 80% after deductible	Plan pays 60% after deductible
Behavioral/ Mental Health Office Visits	Plan pays 80% after deductible	Plan pays 60% after deductible
Durable Medical Equipment (DME)	Includes DME rentals and purchases as defined and covered under the Plan (requires pre-cert for DME over \$1,000)	
	Plan pays 80% after deductible	Plan pays 60% after deductible
Choice Prescription Drugs		
Rx Services		
Out-of-Pocket Maximum (separate from medical)	You pay \$4,300/ Individual \$6,300/ Family	
Annual Deductible	You pay \$50/person for Retail brand drugs (waived on Generic and all Mail order)	
Retail – 30 Day <ul style="list-style-type: none"> Generic Formulary Non-Formulary 	<ul style="list-style-type: none"> You pay 20% (min \$5 max \$50) You pay 25% (min \$30 max \$100) You pay 40% (min \$50 max \$150) 	
Mail Order – 90 Day <ul style="list-style-type: none"> Generic Formulary Brand Non-Formulary Brand 	<ul style="list-style-type: none"> You pay 20% (min \$12.50 max \$100) You pay 25% (min \$75 max \$200) You pay 40% (min \$125 max \$300) 	

Medical Services	Copay Choice PPO Plan Schedule of Benefits	
	In-Network	Out-of-Network
Annual Deductible	\$0	You pay \$1,000/ Individual \$3,000/ Family
Coinsurance	N/A	Plan pays 60% after deductible
Annual Out-of-Pocket Maximum (includes deductible)	You pay \$3,300/ Individual \$6,600/ Family	None
Physician Office Visit	You pay \$20 copay	Plan pays 60% after deductible
ER Room Visit	You pay \$100 copay (emergency services only) (\$200 if admitted)	You pay \$100 copay (emergency services only) (\$200 if admitted)
Urgent Care Facility	You pay \$50 copay	Plan pays 60% after deductible
Preventive Care & Immunizations	Plan pays 100%	Not Covered
Alternative Health Care (acupuncture, naturopath, homeopath)	Not Covered	Not Covered
Hospital Services (require pre-cert)	You pay OP/\$100 copay; IP/\$200 copay	Plan pays 60% after deductible
Outpatient Surgery Services (require pre-cert)	You pay \$100 copay	Plan pays 60% after deductible
Skilled Nursing Facility (SNF)/Sub-Acute Care Facility (LTAC) (require pre-cert and physician authorization)	You pay \$200 copay per admission; maximum of 60 days/person/year combined SNF and LTAC	Plan pays 60% after deductible to a maximum of 60 days/person/year (combined with in-network)
Home Health Care/Home Hospice/Home Infusion Skilled Nursing Services (require pre-cert)	Plan pays 100% to a maximum of 60 visits/person/year	Plan pays 60% after deductible to a maximum of 60 visits/person/year (combined with in-network)
Rehabilitation Services	Physical, occupational, pulmonary, cardiac, music and speech therapy as defined under the plan	
	You pay \$20 copay	Plan pays 60% after deductible
Chiropractic visits (25/person/calendar year)	You pay \$20 copay	Plan pays 60% after deductible
X-Ray, Diagnostic	Plan pays 100%	Plan pays 60% after deductible
Behavioral/ Mental Health Office Visits	You pay \$20 copay	Plan pays 60% after deductible
Durable Medical Equipment (DME)	Includes DME rentals and purchases as defined and covered under the Plan (requires pre-cert for DME over \$1,000)	
	You pay \$20 copay/monthly rental/item/supply	Plan pays 60% after deductible
Copay Choice Prescription Drugs		
Rx Services		
Annual Out-of-Pocket Maximum (separate from medical)	You pay \$3,300/ Individual \$6,600/ Family	
Annual Deductible	None	
Retail – 30 Day <ul style="list-style-type: none"> • Generic • Formulary Brand • Non-Formulary Brand 	<ul style="list-style-type: none"> • You pay \$10 • You pay \$40 • You pay \$75 	

Mail Order – 90 Day <ul style="list-style-type: none">• Generic• Formulary Brand• Non-Formulary Brand	<ul style="list-style-type: none">• You pay \$20• You pay \$80• You pay \$150
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